



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

EDINBURG REGIONAL MEDICAL CENTER

3255 W PIONEER PKWY

ARLINGTON, TX 76013

Respondent Name

ACE AMERICAN INSURANCE CO

MFDR Tracking Number

M4-07-6441-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated May 22, 2007: "This claim has been partially reimbursed; however, it was not paid according to the Acute Care Hospital Fee Guidelines set forth by the TWCC. "

Amount in Dispute: \$4,318.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated June 1, 2007: The Carrier did not submit a position; however MFDR was acknowledged..

Response Submitted by: Ace American Insurance Co. 115 Wild Basin Rd, Ste 207, West Lake Hills, TX 78746.

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
October 30, 2006 through November 5, 2006	Inpatient Hospital Services	\$4,318.10	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. on or after January 15, 2007, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee

guidelines for inpatient services rendered in an acute care hospital.

The services in dispute were reduced/denied by the respondent with the following reason codes:

- W1 – Workers compensation state fee schedule adjustment. (080) Review of this bill has resulted in an adjusted reimbursement of \$0.00. (080) Review of this bill has resulted in an adjusted reimbursement of \$50,445.00.
- W3 – Additional payment made on appeal/reconsideration. (920-011) Upon receipt of additional information (other than a report) from the provider, the recommended allowance has been revised.
- W1 – Workers compensation state fee schedule adjustment. (080) Review of this bill has resulted in an adjusted reimbursement of \$0.00. (080) Review of this bill has resulted in an adjusted reimbursement of \$50,445.00. (400-001) the inpatient reimbursement has been based on per diem, stoploss factor or billed charges whichever is less.
- W3 – Additional payment made on appeal/reconsideration. (920-011) Upon receipt of additional information (other than a report) from the provider, the recommended allowance has been revised.
- W4 – No additional reimbursement allowed after review of appeal/reconsideration. (920-002) In response to a provider inquiry, we have re-analyzed this bill and arrived at the same recommended allowance.

Issues

1. Did the audited charges exceed \$40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 South Western Reporter Third 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges **in this case** exceed \$40,000; whether the admission and disputed services **in this case** are unusually extensive; and whether the admission and disputed services **in this case** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection..." 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "...to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "...Audited charges are those charges which remain after a bill review by the insurance carrier has been performed..." Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal \$86,362.00. The division concludes that the total audited charges exceed \$40,000.
2. The requestor in its original position statement asserts that "Rule 134.401 (c) (4) states claims that reach the \$40,000 Stop-Loss threshold are reimbursed at 75% of charges." In its position statement, the requestor presupposes that it is entitled to the stop loss method of payment because the audited charges exceed \$40,000. As noted above, the Third Court of Appeals in its November 13, 2008 rendered judgment to the contrary. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved...unusually

extensive services.” The requestor failed to discuss or demonstrate that the particulars of the admission in dispute that constitute unusually extensive services; therefore, the division finds that the requestor did not meet 28 TAC §134.401(c)(6).

3. In regards to whether the services were unusually costly, the requestor presupposes that because the bill exceeds \$40,000, the stop loss method of payment should apply. The third Court of Appeals’ November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must **demonstrate** that an admission involved unusually costly services thereby affirming 28 Texas Administrative Code §134.401(c)(6) which states that “Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker.” The requestor failed to discuss the particulars of the admission in dispute that may constitute unusually costly services; therefore, the division finds that the requestor failed to meet 28 TAC §134.401(c)(6).
4. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements*. The division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.
 - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of \$1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that “The applicable Workers’ Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission...” The length of stay was six days. The surgical per diem rate of \$1,118.00 multiplied by the length of stay of six days results in an allowable amount of \$6,708.00.
 - Review of the medical documentation provided finds that although the requestor billed items under revenue code(s) 275, 276 or 278, no invoices were found to support the cost of the implantables billed. For that reason, no additional reimbursement is recommended

The division concludes that the total allowable for this admission is \$6,708.00 per diem. The respondent issued payment in the amount of \$60,453.40. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed \$40,000, but failed to discuss and demonstrate that the disputed inpatient hospital admission involved unusually extensive, and unusually costly services. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount*, and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	October 22, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.